5101:3-3-28 Change in ownership/recovery of excess depreciation.

(A) A "sale of a nursing home from one party to another" is defined as the transfer of ownership or control (as defined in paragraph (B) of rule 5101:3-3-26 of the Administrative Code) from one unrelated party to another (as defined in paragraph (B)(3) of rule 5101:3-3-24 of the Administrative Code.

(B) The owner of a long-term care facility participating in the medicaid program shall provide at least forty-five days written notice prior to entering into any contract of sale for the home. For purpose of this rule, "entering any contract" is defined as the effective date of the sale regardless of the effective date of participation in the medicaid program for the new owner.

(1) In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable state law, constitutes change of ownership.

(2) In the case of a unincorporated sole proprietorship, the transfer of title and property to another party constitutes change of ownership.

(3) In the case of a corporation, the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

(4) In the case of leasing, the lease of all or part of a provider facility constitutes change of ownership of the leased portion.

(C) The provisions contained in paragraphs (D), (E), and (I) of this rule do not apply if the prospective owner is purchasing both the assets and liabilities from the current owner.

(D) If the prospective owner is not purchasing both the assets and liabilities of the previous owner, the department shall place in escrow in a bank, trust company, or savings and loan institution the last two monthly medicaid payments upon being notified of the change in ownership by the department of health, the current owner, or the prospective owner. The two months payments subject to such a withholding are the two months (or portion thereof) preceding the effective date of the sale.

(E) The last two months of medicaid payments shall be held in escrow until:

(1) An audit is conducted pursuant to paragraph (G) of this rule and funds are disbursed pursuant to paragraph (H) of this rule.

(2) The department is notified by notarized statement that the sale did not materialize.

(F) The individual/partnership/corporation selling a nursing home shall file a cost report as provided for under rule 5101:3-3-26 of the Administrative Code within ninety days after the sale is finalized.

(G) Within sixty days following the filing of a cost report as required by paragraph (F) of this rule, the department shall complete an audit in accordance with provisions contained in rule 5101:3-3-27 of the Administrative Code.

(1) Any audit not initiated by the department within sixty days following the filing of a cost report shall result in the monies held in escrow pursuant to paragraph (D) of this rule being released to the previous owner.

(2) Any audit not finalized by the department within sixty days shall result in the monies held in escrow pursuant to paragraph (D) of this rule being released to the previous owner if the previous owner supplied financial and statistical information as requested.

(3) Failure to supply within fourteen days requested financial and statistical information necessary to fulfill the scope of the audit in accordance with generally accredited auditing standards constitutes an exten-

sion of the time period listed in paragraph (G)(2). The extension shall be no more than fourteen days after the requested information was supplied unless additional time is mutually agreed upon by both parties.

(H) The audit conducted by the department shall identify:

(1) Any monies owed to or by the department pursuant to rule 5101:3-3-27 of the Administrative Code.

(2) Any monies to the department for the recapture of excess depreciation calculated pursuant to paragraph (K) of this rule.

(I) Within fifteen days after the previous owner agrees to the findings of the audit:

(1) Any funds held in escrow including interest earned on such funds, less any amounts due the department, shall be released to the previous owner.

(2) If the funds held in escrow plus interest are less than the amount due to the department, the previous owner shall pay the department within fifteen days the amount due less the amount disbursed in paragraph (I)(1) of this rule.

(3) If the funds held in escrow (excluding interest) are less than the amount due to the previous owner, the department shall authorize payment within fifteen days of the amount due less the amount disbursed in paragraph (I)(1) of this rule.

(J) Within fifteen days after the current owner, if he has purchased both assests and liabilities from the previous owner, agrees to the findings of the audit conducted pursuant to paragraph (H) of this rule, any monies owned to or by the department shall be paid.

(K) The amount of depreciation paid to the provider by the department pursuant to paragraph (A) of rule 5101:3-3-22 of the Administrative Code is to be repaid to the department by the provider if an ownership change occurs during the first ten years of the provider's participation in the medicaid program.

(1) Only the amount of depreciation paid by the department that is equal to or less than the difference between original and new purchase price is due the department.

(2) Only the amount of depreciation actually paid by the department is due the department. In situations where the interest expense and depreciation allowance exceeds the property ownership ceilings specified in rule 5101:3-3-22 of the Administrative Code, only the difference between the property ownership ceiling and the interest is due the department by the provider.

(3) Only the amount of depreciation paid by the department, after the provision of paragraphs (K)(1) and (K)(2) of this rule have been applied, during the first ten years the facility participated in the medicaid program is due to the department.

(a) If a change of ownership occurred before the beginning of the sixth year of medicaid participation, the full amount of depreciation paid is repayable.

(b) If a change of ownership occurred between the fifth and tenth year of medicaid participation, the amount repayable is the amount of depreciation paid multiplied by twenty per cent multiplied by the number of years less than ten that the facility participated in the medicaid program.

(c) If a change of ownership occurred after the tenth year of medicaid participation, there is no amount repayable by the provider for the depreciation paid by the department.

(4) Only the depreciation paid by the department since August 1, 1980 is subject to the depreciation repayment provisions of paragraphs (K)(1) to (K)(3) of this rule.

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5101:3-3-40 NURSING FACILITY (NF) CASE MIX ASSESSMENT INSTRUMENT: MINIMUM DATA SET VERSION 2.0 (MDS2.0).

(A) AS USED IN THIS RULE:

(1) "ANNUAL FACILITY AVERAGE CASE MIX SCORE" IS THE SCORE USED TO CALCULATE THE FACILITY'S COST PER CASE MIX UNIT, AND IS CALCULATED USING THE METHODOLOGY DESCRIBED IN PARAGRAPH (E) OF RULE 5101:3-3-42 OF THE ADMINISTRATIVE CODE.

(2) "CASE MIX REPORT" IS A REPORT GENERATED BY THE OHIO DEPARTMENT OF HUMAN SERVICES (ODHS) AND DISTRIBUTED TO THE NF ON THE STATUS OF ALL MDS2.0 ASSESSMENT DATA THAT PERTAINS TO THE CALCULATION OF A QUARTERLY OR AN ANNUAL AVERAGE FACILITY CASE MIX SCORE.

(3) "COMPREHENSIVE ASSESSMENT" MEANS AN ASSESSMENT THAT INCLUDES COMPLETION OF NOT ONLY THE MDS2.0 DESIGNATED FOR USE IN OHIO BUT ALSO THE TRIGGERS, RESIDENT ASSESSMENT PROTOCOLS (RAPS), AND "RAP SUMMARY" FORM.

(4) "CRITICAL ELEMENTS" ARE DATA ITEMS FROM A RESIDENT'S MINIMUM DATA SET VERSION 2.0 (MDS2.0) THAT ODHS VERIFIES PRIOR TO DETERMINING A RESIDENT'S RESOURCE UTILIZATION GROUP, VERSION III (RUG III) CLASS.

(5) "CRITICAL ERRORS" ARE ERRORS IN THE MDS2.0 CRITICAL ELEMENTS, SUCH AS OMISSIONS OR OUT-OF-RANGE RESPONSES, THAT PREVENT ODHS FROM DETERMINING THE RESIDENT'S RUG III CLASSIFICATION.

(6) "COST PER CASE MIX UNIT" IS CALCULATED BY DIVIDING THE FACILITY'S DESK-REVIEWED, ACTUAL, ALLOWABLE PER DIEM DIRECT CARE COSTS FOR THE CALENDAR YEAR PRECEDING THE FISCAL YEAR IN WHICH THE RATE WILL BE PAID BY THE ANNUAL FACILITY AVERAGE CASE MIX SCORE FOR THE CALENDAR YEAR PRECEDING THE FISCAL YEAR IN WHICH THE RATE WILL BE PAID. THE LESSER OF THE FACILITY'S COST PER CASE MIX UNIT OR THE MAXIMUM ALLOWABLE COST PER CASE MIX UNIT FOR THE FACILITY'S PEER GROUP FOR THE FISCAL YEAR SHALL BE USED TO DETERMINE THE FACILITY'S RATE FOR DIRECT CARE COSTS, IN ACCORDANCE WITH RULE 5101:3-3-44 OF THE ADMINISTRATIVE CODE.

(7) "DEFAULT GROUP" IS RUG III GROUP FORTY-FIVE, THE CASE MIX GROUP ASSIGNED TO RESIDENTS FOR WHOM MISSING OR INACCURATE DATA PRECLUDES CLASSIFICATION INTO RUG III GROUPS ONE THROUGH FORTY-FOUR.

(8) "DIRECT CARE PEER GROUP" IS A GROUP OF OHIO MEDICAID-CERTIFIED NFS DETERMINED BY ODHS TO HAVE SIGNIFICANT PER DIEM DIRECT CARE COST DIFFERENCES FROM THE OTHER DIRECT CARE PEER GROUPS DUE TO REASONS OTHER THAN THE DIFFERENCES IN CARE NEEDS AMONG THE RESIDENTS. DIRECT CARE PEER GROUPS ARE DESCRIBED IN RULE 5101:3-3-44 OF THE ADMINISTRATIVE CODE.

(9) "ENCODED," WHEN USED WITH REFERENCE TO A RECORD, MEANS THAT THE RECORD HAS BEEN RECORDED IN ELECTRONIC FORMAT. THE RECORD MUST BE ENCODED IN

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ACCORDANCE WITH THE UNITED STATES HEALTH CARE FINANCING ADMINISTRATION (HCFA) UNIFORM DATA SUBMISSION DOCUMENT AND STATE SPECIFICATIONS.

(10) "FILING DATE" IS THE DEADLINE FOR SUBMISSION OF THE NF'S MDS2.0 ASSESSMENT DATA THAT WILL BE USED FOR RATE SETTING PURPOSES. THE FILING DATE IS THE FIFTEENTH CALENDAR DAY FOLLOWING THE REPORTING PERIOD END DATE.

(11) "LOCKED" MEANS A RECORD IS CONSIDERED FINAL AND CANNOT BE ALTERED, IN ACCORDANCE WITH 42 C.F.R. 483.20 AND PARAGRAPH (D)(1) OF THIS RULE.

(12) "MEDICARE REQUIRED ASSESSMENT" MEANS THE MDS2.0 SPECIFIED FOR USE IN OHIO THAT IS REQUIRED ONLY FOR FACILITIES PARTICIPATING IN THE MEDICARE PROSPECTIVE PAYMENT SYSTEM BUT DOES NOT INCLUDE THE TRIGGERS, RESIDENT ASSESSMENT PROTOCOLS (RAPS), AND RAP SUMMARY FORM.

(13) "MINIMUM DATA SET (MDS2.0)" IS THE CORE SET OF SCREENING AND ASSESSMENT ELEMENTS DESIGNATED BY OHIO AND APPROVED BY HCFA THAT FORMS THE FOUNDATION OF THE COMPREHENSIVE ASSESSMENT FOR ALL RESIDENTS OF LONG TERM CARE FACILITIES CERTIFIED TO PARTICIPATE IN MEDICAID AND MEDICARE. THE MDS2.0 PROVIDES THE RESIDENT ASSESSMENT DATA WHICH IS USED TO CLASSIFY THE RESIDENT INTO A RESOURCE UTILIZATION GROUP (RUG) IN THE RUG III CASE MIX CLASSIFICATION SYSTEM.

(14) "PAYMENT QUARTER" IS THE QUARTER FOLLOWING THE PROCESSING QUARTER AND IS THE QUARTER IN WHICH THE DIRECT CARE RATE IS PAID BASED ON THE QUARTERLY FACILITY AVERAGE CASE MIX SCORE FROM THE REPORTING QUARTER'S MDS2.0 DATA.

(15) "PROCESSING QUARTER" IS THE QUARTER THAT FOLLOWS THE REPORTING QUARTER AND IS THE QUARTER IN WHICH ODHS CALCULATES THE QUARTERLY FACILITY AVERAGE CASE MIX SCORE.

(16) "QUARTERLY FACILITY AVERAGE CASE MIX SCORE" IS THE FACILITY AVERAGE CASE MIX SCORE BASED ON DATA SUBMITTED FOR ONE REPORTING QUARTER AND IS CALCULATED USING THE METHODOLOGY DESCRIBED IN RULE 5101:3-3-42 OF THE ADMINISTRATIVE CODE.

(17) "QUARTERLY REVIEW ASSESSMENT" MEANS AN ASSESSMENT THAT IS NORMALLY CONDUCTED NO LESS THAN ONCE EVERY THREE MONTHS USING THE MDS2.0 DESIGNATED FOR USE IN OHIO THAT DOES NOT INCLUDE THE TRIGGERS, RESIDENT ASSESSMENT PROTOCOLS (RAPS), AND RAP SUMMARY FORM.

(18) "RECORD" MEANS A RESIDENT'S ENCODED MDS2.0 ASSESSMENT AS DESCRIBED IN PARAGRAPHS (B)(1) TO (B)(3) OF THIS RULE.

(19) "RELATIVE RESOURCE WEIGHT" IS THE MEASURE OF THE RELATIVE COSTLINESS OF CARING FOR RESIDENTS IN ONE CASE MIX GROUP VERSUS ANOTHER, INDICATING THE RELATIVE AMOUNT AND COST OF STAFF TIME REQUIRED ON AVERAGE FOR DEFINED WORKER CLASSIFICATIONS TO CARE FOR RESIDENTS IN A SINGLE CASE MIX GROUP. THE METHODOLOGY FOR CALCULATING RELATIVE RESOURCE WEIGHTS IS DESCRIBED IN RULE 5101:3-3-41 OF THE ADMINISTRATIVE CODE.

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(20) "REPORTING PERIOD END DATE" IS THE LAST DAY OF THE CALENDAR QUARTER.

(21) "REPORTING QUARTER" IS THE CALENDAR QUARTER IN WHICH THE MDS2.0 IS CONDUCTED, AS INDICATED BY THE ASSESSMENT REFERENCE DATE IN MDS2.0 SECTION A, ITEM 3a, EXCEPT AS SPECIFIED IN PARAGRAPHS (C)(7) AND (C)(9) OF THIS RULE.

(22) "RESIDENT ASSESSMENT INSTRUMENT (RAI)" IS THE INSTRUMENT USED BY NFS IN OHIO TO COMPLY WITH 42 CFR SECTION 483.20 AND PROVIDES A COMPREHENSIVE, ACCURATE, STANDARDIZED, REPRODUCIBLE ASSESSMENT OF EACH LONG TERM CARE FACILITY RESIDENT'S FUNCTIONAL CAPABILITIES AND IDENTIFIES MEDICAL PROBLEMS. THE OHIO-SPECIFIED AND FEDERALLY-APPROVED INSTRUMENT IS COMPOSED OF THE MDS2.0, TRIGGERS, RESIDENT ASSESSMENT PROTOCOLS (RAPS) AND THE RAP SUMMARY FORM.

(23) "RESIDENT ASSESSMENT PROTOCOLS (RAPS)" ARE STRUCTURED, PROBLEM-ORIENTED FRAMEWORKS FOR ORGANIZING MDS INFORMATION, AND FORMS THE BASIS FOR INDIVIDUALIZED CARE PLANNING.

(24) THE "RESIDENT ASSESSMENT PROTOCOL (RAP) SUMMARY" FORM IS USED TO DOCUMENT WHICH RAPS WERE TRIGGERED, WHETHER OR NOT CARE PLANNING WILL BE DONE FOR THE TRIGGERED CONDITION AND WHERE SUMMARY DATA FROM THE RAP REVIEW PROCESS IS DOCUMENTED. IT IS PART OF THE RAI AND MUST BE COMPLETED FOR ALL COMPREHENSIVE ASSESSMENTS.

(25) "RESIDENT CASE MIX SCORE" IS THE RELATIVE RESOURCE WEIGHT FOR THE RUG III GROUP TO WHICH THE RESIDENT IS ASSIGNED BASED ON DATA ELEMENTS FROM THE RESIDENT'S MDS2.0 ASSESSMENT.

(26) "RUG III" IS THE RESOURCE UTILIZATION GROUPS, VERSION III SYSTEM OF CLASSIFYING NF RESIDENTS INTO CASE MIX GROUPS DESCRIBED IN RULE 5101:3-3-41 OF THE ADMINISTRATIVE CODE. RESOURCE UTILIZATION GROUPS ARE CLUSTERS OF NF RESIDENTS, DEFINED BY RESIDENT CHARACTERISTICS, THAT EXPLAIN RESOURCE USE.

(27) "TRIGGERS" ARE SPECIFIC RESIDENT RESPONSES FOR ONE OR A COMBINATION OF MDS2.0 ELEMENTS. THESE TRIGGERS IDENTIFY RESIDENTS WHO REQUIRE FURTHER EVALUATION USING RESIDENT ASSESSMENT PROTOCOLS DESIGNATED WITHIN THE STATE SPECIFIED RAI.

(B) FOR THE PURPOSE OF DETERMINING MEDICAID PAYMENT RATES FOR NFS EFFECTIVE OCTOBER 1, 1998 AND THEREAFTER, ODHS SHALL ACCEPT THE RAI SPECIFIED BY THE STATE AND APPROVED BY HCFA EFFECTIVE APRIL 1, 1998. EACH NF SHALL ASSESS ALL RESIDENTS OF MEDICAID-CERTIFIED BEDS, DEFINED IN PARAGRAPH (C) OF THIS RULE, USING THE MDS2.0 AS SET FORTH IN APPENDIX A OF THIS RULE.

(1) COMPREHENSIVE ASSESSMENTS, MEDICARE-REQUIRED ASSESSMENTS, QUARTERLY REVIEW ASSESSMENTS AND SIGNIFICANT CORRECTIONS OF QUARTERLY ASSESSMENTS MUST BE CONDUCTED IN ACCORDANCE WITH THE REQUIREMENTS AND FREQUENCY SCHEDULE FOUND AT 42 CFR SECTION 483.20.

(a) EFFECTIVE APRIL 1, 1998, COMPREHENSIVE ASSESSMENTS, INCLUDING THE MDS2.0, TRIGGERS, RAPS AND RAPS SUMMARY, ARE REQUIRED FOR ALL INITIAL ASSESSMENTS, SIGNIFICANT CHANGE ASSESSMENTS , ANNUAL ASSESSMENTS AND SIGNIFICANT CORRECTION OF PREVIOUS COMPREHENSIVE ASSESSMENTS.

(b) EFFECTIVE APRIL 1, 1998, THE MDS.2.0 IS REQUIRED FOR ALL MEDICARE-REQUIRED ASSESSMENTS, QUARTERLY ASSESSMENTS, SIGNIFICANT CORRECTIONS OF PREVIOUS QUARTERLY ASSESSMENTS, AND SIGNIFICANT CORRECTIONS OF PREVIOUS MEDICARE REQUIRED ASSESSMENTS.

(2) AS SET FORTH IN APPENDIX A, EFFECTIVE APRIL 1, 1998, NFS MUST USE THE OHIO-SPECIFIED MDS2.0 INCLUDING SECTIONS S, T, AND U FOR ALL COMPREHENSIVE ASSESSMENTS, MEDICARE-REQUIRED ASSESSMENTS, QUARTERLY REVIEW ASSESSMENTS, SIGNIFICANT CHANGE ASSESSMENTS AND SIGNIFICANT CORRECTION ASSESSMENTS.

(3) EFFECTIVE APRIL 1, 1998, NFS MUST USE THE MDS2.0 DISCHARGE TRACKING FORM AS SET FORTH IN APPENDIX B OF THIS RULE FOR ANY RESIDENTS WHO TRANSFER, ARE DISCHARGED OR EXPIRE, AND THE MDS2.0 REENTRY TRACKING FORM AS SET FORTH IN APPENDIX C OF THIS RULE FOR ANY RESIDENTS REENTERING THE FACILITY IN ACCORDANCE WITH 42 CFR SECTION 483.20.

(C) EFFECTIVE JULY 1, 1998, ALL NFS MUST SUBMIT TO THE STATE ENCODED, ACCURATE, AND COMPLETE MDS2.0 DATA FOR ALL RESIDENTS OF MEDICAID-CERTIFIED NF BEDS, REGARDLESS OF PAY SOURCE OR ANTICIPATED LENGTH OF STAY.

(1) MDS2.0 DATA COMPLETED IN ACCORDANCE WITH PARAGRAPHS (B)(1) TO (B)(3) OF THIS RULE MUST BE ENCODED IN ACCORDANCE WITH 42 CFR SECTION 483.20, HCFA'S UNIFORM DATA SUBMISSION DOCUMENT, AND STATE RECORD LAYOUT SPECIFICATIONS.

(2) MDS2.0 DATA MUST BE SUBMITTED IN AN ELECTRONIC FORMAT VIA MODEM AND IN ACCORDANCE WITH THE FREQUENCY SCHEDULE FOUND IN 42 CFR SECTION 483.20. THE DATA MAY BE SUBMITTED AT ANY TIME DURING THE REPORTING QUARTER THAT IS PERMITTED BY INSTRUCTIONS ISSUED BY THE STATE, BUT, EXCEPT AS PROVIDED IN PARAGRAPHS (D) AND (E) OF THIS RULE, ALL RECORDS USED IN QUARTERLY RATE-SETTING MUST BE SUBMITTED BY THE FILING DATE.

(3) IF A NF SUBMITS MDS2.0 DATA NEEDED FOR QUARTERLY RATE-SETTING AFTER THE FILING DATE, ODHS MAY ASSIGN, FOR A PERIOD OF NOT MORE THAN ONE MONTH PER QUARTER, A QUARTERLY FACILITY AVERAGE CASE MIX SCORE AS SET FORTH IN PARAGRAPH (E) OF RULE 5101:3-3-42 OF THE ADMINISTRATIVE CODE.

(4) DATA SUBMITTED ELECTRONICALLY BY A NF DOES NOT MEET THE REQUIREMENTS FOR TIMELY AND ACCURATE SUBMISSION IF IT CANNOT BE PROCESSED BY ODHS (FOR EXAMPLE, REJECTION OF THE ENTIRE DATA FILE, SUBMISSION OF A BLANK FILE, ETC.) AND MAY RESULT IN ASSIGNMENT OF A QUARTERLY AVERAGE CASE MIX SCORE AS SET FORTH IN RULE 5101:3-3-42 OF THE ADMINISTRATIVE CODE.

(5) THE ANNUAL AND QUARTERLY FACILITY AVERAGE CASE MIX SCORES WILL BE CALCULATED USING THE MDS2.0 RECORD IN EFFECT ON THE REPORTING PERIOD END DATE FOR:

(a) RESIDENTS WHO WERE ADMITTED TO THE MEDICAID CERTIFIED NF PRIOR TO THE REPORTING PERIOD END DATE AND CONTINUE TO BE PHYSICALLY PRESENT IN THE NF ON THE REPORTING PERIOD END DATE; AND

(b) RESIDENTS WHO WERE ADMITTED TO THE NF ON THE REPORTING PERIOD END DATE FROM A NON-NF SETTING (HOME, HOSPITAL, ADULT CARE FACILITY, RESIDENTIAL CARE FACILITY, INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF-MR)); AND

(c) RESIDENTS WHO WERE TRANSFERRED INTO THE NF FROM ANOTHER NF ON THE REPORTING PERIOD END DATE; AND

(d) RESIDENTS WHO WERE TEMPORARILY ABSENT ON THE REPORTING PERIOD END DATE BUT ARE CONSIDERED RESIDENTS AND FOR WHOM A BED IS BEING HELD FOR THEIR RETURN FROM HOSPITAL STAYS, VISITS WITH FRIENDS OR RELATIVES, OR PARTICIPATION IN THERAPEUTIC PROGRAMS OUTSIDE THE FACILITY.

(6) RECORDS FOR RESIDENTS WHO WERE PERMANENTLY DISCHARGED FROM THE NF, TRANSFERRED TO ANOTHER NF, OR EXPIRED PRIOR TO OR ON THE REPORTING PERIOD END DATE WILL NOT BE USED FOR RATE SETTING.

(7) FOR A RESIDENT ADMITTED WITHIN FOURTEEN DAYS OF THE REPORTING PERIOD END DATE, AND WHOSE INITIAL ASSESSMENT IS NOT DUE UNTIL AFTER THE REPORTING PERIOD END DATE, BOTH OF THE FOLLOWING SHALL APPLY:

(a) THE NF SHALL SUBMIT THE APPROPRIATE INITIAL ASSESSMENT AS SPECIFIED IN THE MDS2.0 MANUAL AND IN 42 CFR 483.20; AND

(b) THE INITIAL ASSESSMENT, IF COMPLETED AND SUBMITTED TIMELY IN ACCORDANCE WITH PARAGRAPH (C)(7)(a) OF THIS RULE, SHALL BE USED FOR RATE SETTING IN THE QUARTER THE RESIDENT ENTERED THE FACILITY EVEN IF THE ASSESSMENT REFERENCE DATE IS AFTER THE REPORTING PERIOD END DATE.

(8) A RESIDENT SPECIFIC CASE MIX SCORE WILL BE ASSIGNED FOR A RESIDENT OF THE FACILITY ON THE REPORTING PERIOD END DATE WHO WAS EITHER:

(a) ADMITTED IN THE FINAL FOURTEEN DAYS OF THE CALENDAR QUARTER AND WHOSE INITIAL ASSESSMENT WAS NOT COMPLETED BECAUSE THE RESIDENT WAS DISCHARGED OR EXPIRED, OR

(b) ADMITTED IN THE FINAL THIRTY DAYS OF THE CALENDAR QUARTER AND RETURNED TO THE HOSPITAL PRIOR TO THE COMPLETION OF THE INITIAL ASSESSMENT, AND IS STILL IN THE HOSPITAL ON THE REPORTING PERIOD END DATE.

(c) THE RESIDENT SPECIFIC CASE MIX SCORE SHALL BE ASSIGNED AS FOLLOWS:

(i) THE FACILITY SHALL SUBMIT THE RESIDENT'S DISCHARGE TRACKING RECORD, AND

(ii) THE REASON FOR ASSESSMENT (MDS2.0, ITEM AA8a) SHALL BE CODED AS "EIGHT", "DISCHARGED PRIOR TO COMPLETING INITIAL ASSESSMENT

(iii) THE DISCHARGE STATUS (MDS2.0, ITEM R3) SHALL BE CODED "ONE" THROUGH "NINE" AS APPROPRIATE.

(iv) ODHS SHALL GROUP THE RESIDENT INTO THE CLINICALLY COMPLEX CATEGORY, GROUP TWENTY TWO, CLASS "CC1".

(9) FOR A RESIDENT WHO HAD AT LEAST ONE MDS2.0 ASSESSMENT COMPLETED BEFORE BEING TRANSFERRED TO A HOSPITAL, REENTERS THE NF WITHIN FOURTEEN DAYS OF THE REPORTING PERIOD END DATE, AND HAS EXPERIENCED A SIGNIFICANT CHANGE IN STATUS THAT REQUIRES A COMPREHENSIVE ASSESSMENT UPON REENTRY,

(a) THE NF SHALL SUBMIT A SIGNIFICANT CHANGE ASSESSMENT WITHIN FOURTEEN DAYS OF REENTRY, AS INDICATED BY THE MDS2.0 ASSESSMENT REFERENCE DATE (MDS2.0, ITEM A3)

(b) THE SIGNIFICANT CHANGE ASSESSMENT SHALL BE USED FOR RATE SETTING FOR THE QUARTER IN WHICH THE RESIDENT REENTERED THE FACILITY EVEN IF THE ASSESSMENT REFERENCE DATE IS AFTER THE REPORTING PERIOD END DATE.

(D) CORRECTIONS TO MDS DATA MUST BE MADE IN ACCORDANCE WITH THE REQUIREMENTS IN THE "LONG TERM CARE FACILITY (LTCF) RAI USER'S MANUAL" VERSION 2.0 AND THE "STATE OPERATION MANUAL" (SOM) ISSUED BY HCFA.

(1) CORRECTIONS TO CLINICAL DATA CAN BE MADE AS FOLLOWS:

(a) CORRECTIONS MAY BE MADE TO KEY FIELDS AS SPECIFIED BY HCFA.

(b) WITHIN SEVEN DAYS AFTER COMPLETION OF THE MDS2.0, AS SPECIFIED IN THE "LTCF RAI USER'S MANUAL" VERSION 2.0 AND THE SOM ISSUED BY HCFA, AND PRIOR TO TRANSMISSION TO THE STATE. A RECORD WILL BE CONSIDERED LOCKED AFTER SEVEN DAYS OR TRANSMISSION TO THE STATE, WHICHEVER OCCURS FIRST.

(c) AFTER THE RECORD IS LOCKED, CORRECTION TO THE CLINICAL DATA CAN ONLY BE MADE BY COMPLETING A SIGNIFICANT CORRECTION ASSESSMENT OR, IF THERE HAS ACTUALLY BEEN A SIGNIFICANT CHANGE IN STATUS, A COMPREHENSIVE SIGNIFICANT CHANGE ASSESSMENT. THESE ASSESSMENTS MUST BE COMPLETED IN ACCORDANCE WITH THE INSTRUCTIONS IN THE "LTCF RAI USER'S MANUAL" VERSION 2.0 AND THE SOM AS ISSUED BY HCFA, AND REQUIRE A NEW OBSERVATION PERIOD AND ASSESSMENT REFERENCE DATE.

(d) FOR RATE-SETTING PURPOSES, SIGNIFICANT CORRECTION ASSESSMENTS MUST HAVE AN ASSESSMENT REFERENCE DATE WITHIN THE REPORTING QUARTER.

(e) FOR RATE-SETTING PURPOSES, SIGNIFICANT CHANGE ASSESSMENTS MUST HAVE AN ASSESSMENT REFERENCE DATE WITHIN THE REPORTING QUARTER EXCEPT WHEN USED TO REPORT A SIGNIFICANT CHANGE IN A RESIDENT'S STATUS UPON RETURN FROM A HOSPITAL AS SPECIFIED IN PARAGRAPH (C)(9) OF THIS RULE.

(2) IT IS THE PROVIDER'S RESPONSIBILITY TO SUBMIT AN ACCURATE, ENCODED MDS2.0 RECORD FOR EACH RESIDENT IN A MEDICAID-CERTIFIED BED ON THE LAST DAY OF THE CALENDAR QUARTER.

(a) THE FACILITY SHALL TRANSMIT MDS2.0 ASSESSMENTS THAT WERE COMPLETED TIMELY BUT INADVERTENTLY OMITTED FROM THE PREVIOUS TRANSMISSIONS, AND ODHS SHALL USE THE ACTUAL CASE MIX SCORES FROM THESE ASSESSMENTS FOR RATE SETTING PURPOSES, IF THE ASSESSMENTS ARE TRANSMITTED WITHIN EIGHTY DAYS AFTER THE REPORTING PERIOD END DATE. IF THE ASSESSMENTS ARE NOT TRANSMITTED WITHIN EIGHTY DAYS AFTER THE REPORTING PERIOD END DATE, ODHS MAY ASSIGN DEFAULT SCORES FOR THOSE RECORDS AS DESCRIBED IN RULE 5101:3-3-41 OF THIS ADMINISTRATIVE CODE.

(b) THE FACILITY HAS EIGHTY DAYS AFTER THE REPORTING PERIOD END DATE TO TRANSMIT THE APPROPRIATE DISCHARGE TRACKING FORM TO THE STATE. IF THE FACILITY IDENTIFIED MORE RESIDENTS AS BEING IN THE FACILITY ON THE REPORTING PERIOD END DATE (RPED) THAN THE NUMBER OF ITS MEDICAID-CERTIFIED BEDS. IF THE FACILITY DOES NOT CORRECT THE ERROR WITHIN EIGHTY DAYS AFTER THE REPORTING PERIOD END DATE, ODHS MAY ASSIGN A FACILITY AVERAGE CASE MIX SCORE AS SPECIFIED IN RULE 5101:3-3-42 OF THE ADMINISTRATIVE CODE.

(c) THE FACILITY SHALL NOTIFY ODHS WITHIN EIGHTY DAYS OF THE REPORTING PERIOD END DATE OF ANY RECORDS FOR RESIDENTS IN MEDICAID-CERTIFIED BEDS ON THE REPORTING PERIOD END DATE THAT WERE NOT COMPLETED TIMELY, AND WERE NOT TRANSMITTED TO THE STATE. ODHS MAY ASSIGN DEFAULT SCORES TO THOSE RECORDS AS DESCRIBED IN RULE 5101:3-3-41 OF THE ADMINISTRATIVE CODE.

(d) THE FACILITY SHALL NOTIFY ODHS WITHIN EIGHTY DAYS OF THE REPORTING PERIOD END DATE OF ANY RESIDENTS WHO WERE REPORTED TO BE RESIDENTS OF THE FACILITY ON THE REPORTING PERIOD END DATE, BUT WHO HAD ACTUALLY BEEN DISCHARGED PRIOR TO THE REPORTING PERIOD END DATE. IF THE FACILITY DOES NOT CORRECT THE ERROR WITHIN EIGHTY DAYS AFTER THE REPORTING PERIOD END DATE, ODHS MAY ASSIGN A FACILITY AVERAGE CASE MIX SCORE AS SPECIFIED IN RULE 5101:3-3-42 OF THE ADMINISTRATIVE CODE.

(3) IF THE NUMBER OF RECORDS ASSIGNED TO THE DEFAULT GROUP IN ACCORDANCE WITH PARAGRAPHS (D)(2)(a) AND (D)(2)(c) OF THIS RULE IS GREATER THAN TEN PER

CENT, ODHS MAY ASSIGN A QUARTERLY FACILITY AVERAGE CASE MIX SCORE, AS SET FORTH IN PARAGRAPH (E) OF RULE 5101:3-3-42 OF THE ADMINISTRATIVE CODE.

(E) ALL NFS SUBMITTING MDS2.0 DATA FOR RATE-SETTING PURPOSES MUST BE APPROVED FOR ELECTRONIC SUBMISSION IN ACCORDANCE WITH TECHNICAL INSTRUCTIONS ISSUED BY THE STATE.

(1) NFS ARE RESPONSIBLE FOR TRANSMITTING ALL MDS2.0 DATA USED FOR RATE-SETTING TIMELY AND IN AN APPROVED FORMAT. AS SPECIFIED IN PARAGRAPH (C)(4) OF THIS RULE, MDS2.0 RECORDS SHALL NOT BE CONSIDERED TO MEET THE REQUIREMENTS FOR TIMELY AND ACCURATE SUBMISSION IF THEY CANNOT BE PROCESSED BY ODHS.

(2) NFS REQUESTING AN EXTENSION OF THE FILING DATE MUST SUBMIT A WRITTEN REQUEST AND SUPPORTING DOCUMENTATION TO ODHS.